STATE OF INDIANA

ADDENDUM 11

Request for Service 10-40

INDIANA DEPARTMENT OF ADMINISTRATION

On Behalf Of

INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION/OFFICE OF MEDICAID POLICY AND PLANNING

Solicitation For:

Risk-Based Managed Care Services to Medicaid Beneficiaries (Hoosier Healthwise/HIP)

Response Due Date: Thursday, April 1, 2010

Stephanie Taylor
IDOA Senior Account Manager for FSSA & DCS
Indiana Government Center South
402 W. Washington St., Room W461
Indianapolis, IN 46204

RFS-10-40
March 26, 2010

1. Changes have been made to Attachment D and are highlighted in red. There are four changes, summaries of which can be found below:

- Distribution of Employer Contributions in HIP
- Podiatry Self-referral
- 5010 Readiness Expectations
- Licensure for Service Authorizations

2. The following attachments have been posted:

- Attachment D (updated per summary provided below)
- Replacement page 16 for HHW Databook (see Round 2 Q&A question #19)

Summary of Changes to Attachment D

Distribution of Employer Contributions in HIP

3.4.2.2 Employer POWER Account Contributions – HIP

In HIP, employers are permitted to contribute up to fifty percent (50%) of the member's annual POWER Account contribution. The Contractor must develop a program to publicize to members and employers that an employer may contribute to the member's POWER Account. Appropriate outreach materials should be developed and the Contractor must assure that its member services staff can address calls from members and employers on this topic. Communications about employer contributions should be on-going and continuous, and the Contractor should consider collecting member employment data in the health screening or other member contacts to use in its outreach efforts. The outreach materials for employers must identify the process the employer can use to contribute to employee POWER Accounts.

Employers shall be allowed to make POWER Account contribution payments on a monthly basis. The Contractor shall also allow employers to make their POWER Account contribution in one, lump sum payment upon request. The Contractor must ensure that lump sum payments are credited against the member's required POWER Account contributions evenly over the member's remaining term of coverage. If an employer fails to provide its share of a member's POWER Account contribution within sixty (60) calendar days of its due date, the member shall have an additional sixty (60) calendar days to pay the overdue amount before being terminated from HIP.

Podiatry Self-referral

5.2 Self-referral Services

Members may not self-refer to a provider who is not enrolled in IHCP. The following services are considered self-referral services. The Indiana Administrative Code 405 IAC 5 (Hoosier Healthwise) and 405 IAC 9-7 (HIP) provides further detail regarding these benefits.

- Podiatric services (Hoosier Healthwise only) may be provided by any provider licensed under IC 25-22.5 (doctor of medicine or doctor of osteopathy) or IC 25-29 (doctor of podiatric medicine) who has entered into a provider agreement under IC 12-15-11.

5010 Readiness Expectations

9.0 Information Systems

The Contractor must have an Information System (IS) sufficient to support the Hoosier Healthwise and HIP program requirements, and the Contractor must be prepared to submit all required data and reports in the format specified by OMPP. The Contractor must maintain an IS with capabilities to perform the data receipt, transmission, integration, management, assessment and system analysis tasks described in this Scope of Work. The Contractor's IS must integrate pharmacy data from the State fiscal agent for utilization analysis, care management activities, POWER Account activities and annual and lifetime benefit calculations. OMPP will provide the Contractor with pharmacy claims data on the Contractor's members on a weekly basis through the State fiscal agent. OMPP will also provide access to real-time pharmacy profiles via a web portal.

In the event the State's technical requirements require amendment during the term of the Contract, the State will work with Contractors in establishing the new technical requirements. The Contractor must be capable of adapting to any new technical requirements established by the State, and the State may require the Contractor to agree in writing to the new requirements. After the Contractor has agreed in writing to a new technical requirement, any Contractor-initiated changes to the requirements shall require OMPP approval and OMPP may require the Contractor to pay for additional costs incurred by the State in implementing the Contractor-initiated change.

The Contractor must have a plan for creating, accessing, storing and transmitting health information data in a manner that is compliant with HIPAA standards for electronic exchange, privacy and security requirements (45 CFR 162 and 164).

The Secretary of the Department of Health and Human Services (HHS) has adopted ASC X12 version 5010 as the next HIPAA standard for HIPAA covered transactions. The final rule was published on January 16, 2009 and all covered entities must be fully compliant on January 1, 2012. Contractors must complete an internal gap analysis to compare their current systems against the 5010 standard. Completion of such analysis will be verified during the readiness review. The Contractor must be ready to begin testing in the 5010

format with the State's fiscal agent and other vendors on January 1, 2011. Readiness to test will be demonstrated during the readiness review process.

Licensure for Service Authorizations

8.3.2 Authorization of Services and Notices of Actions

Clinical professionals who have appropriate clinical expertise in the treatment of a member's condition or disease must make all decisions to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested. Only licensed physicians and nurses may deny a service authorization request or authorize a service in an amount, duration or scope that is less than requested. The Contractor must not provide incentives to utilization management staff or to providers for denying, limiting or discontinuing medically necessary services. OMPP may audit Contractor denials, appeals and authorization requests. OMPP may waive certain administrative requirements, including prior authorization procedures, to the extent that such waivers are allowed by law and are consistent with policy objectives. The Contractor may be required to comply with such waivers and will be provided with prior notice by OMPP. If the Contractor delegates some or all of its prior authorization function to subcontractors, the Contractor must conduct annual audits and ongoing monitoring to ensure the subcontractor's performance complies with the Contract, the Contractor's policies and procedures and state and federal law.

Deleted: Indiana-